PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		15E594	B. WING		06/13/2012
NAME OF F	PROVIDER OR SUPPLIEF	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				136TH ST	
MCGIVN	EY HEALTH CARE	CENTER	CARME	EL, IN 46033	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000					
			170000		
	1	ode Recertification and	K0000		
	State Licensure S	Survey was conducted by			
	the Indiana State	e Department of Health in			
	accordance with	42 CFR 483.70(a).			
	Survey Date: 06	5/13/12			
	Facility Number	: 000545			
	Provider Numbe	er: 15E594			
	AIM Number: 1	00267350			
	Survevor: Mark	Caraher, Life Safety			
	Code Specialist				
	Sout Specialise				
	At this Life Safe	ety Code survey			
		th Care Center was found			
	1	ce with Requirements for			
	_	Medicaid, 42 CFR			
	_	a), Life Safety from Fire			
		ition of the National Fire			
		ciation (NFPA) 101, Life			
	I	SC), Chapter 19, Existing			
		cupancies and 410 IAC			
	16.2.				
	1	acility with a lower level			
	was determined	to be of Type V (111)			
	construction and	fully sprinklered. The			
	facility has a fire	e alarm system with			
	1	in the corridors, in all			
		e corridor and in all			
	_	The facility has a			
	135140111 1001115.	The ractive ital a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of Correction identification number:  15E594	A. BUILDING  B. WING	01 	(X3) DATE SURVEY  COMPLETED  06/13/2012
	ROVIDER OR SUPPLIER EY HEALTH CARE CENTER	2907 E	ADDRESS, CITY, STATE, ZIP COE 136TH ST EL, IN 46033	DE .
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
	capacity of 37 and had a census of 33 at the time of this visit.			
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/15/12.			
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	A. BUILDING 01		COMPLETED	
		15E594		B. WING		06/13/	2012
			B. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				136TH ST		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0020	NFPA 101						
SS=E		ODE STANDARD					
		tor shafts, light and , chutes, and other vertical					
		en floors are enclosed with					
		ing a fire resistance rating of					
		. An atrium may be used in					
	accordance with	8.2.5.6. 19.3.1.1.					
		ation and interview, the	K00	20	DisclaimerPreparation,	<b>.</b>	07/13/2012
	1	ensure 1 of 1 vertical			submission and implementatio of this Plan of Correction does		
	stairwell opening	gs was enclosed with			constitute an admission of/or	1100	
	construction have	ing at least a one hour			agreement with the facts and		
	fire resistance rat	ting. LSC 19.3.1.1			conclusions set forth on the		
	requires any vert	ical opening to be			survey report. McGivney Healt		
	enclosed or prote	ected in accordance with			Care reserves all rights to cont the survey findings through	est	
	LSC 8.2.5. LSC	8.2.5.2 states the vertical			informal dispute resolution, for	mal	
	opening shall be	enclosed as appropriate			appeal proceedings or any		
		ance rating of the barrier.			Administrative or legal		
		quires a one hour rated			proceedings. McGivney Health		
		ar vertical opening. This			Care reserves all rights to raise all possible contentions and	Э	
		e could affect any			defenses in any type of civil or		
	•	nd visitors in the vicinity			criminal claim, action or		
	•	oor by resident Room 7.			proceeding. The facility offers		
	or the stan wen a	oor by resident recent 7.			responses, credible allegations		
	Findings include				compliance and plan of correct as part of its ongoing efforts to		
	Tilldings illetude	•			provide quality care to residen		
	Based on observa	ation with the			McGivney Health Care reserve	es	
					the right to modify policies and	/or	
		d the Maintenance			procedures and quality		
	_	g a tour of the facility			improvement systems as necessary to better meet the		
	from 11:10 a.m.				needs of the residents and the		
	· ·	or at the top of the			facility. The facility does have 1		
	_	lent Room 7 had a fire			1 vertical enclosed concrete		
	_	ed to the door stating the			stairwell opening with a fire		
	door was rated at	a fire resistance of 20			resistance rating of 20 minutes		
	minutes. Based	on interview at the time			which has been on the building since the building was built in t		
					Since the building was built in t	.110	

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	of correction identification number:  15E594	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 06/13/2012
	PROVIDER OR SUPPLIER  JEY HEALTH CARE CENTER	STREET 2 2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	of observation, the Administrator and the Maintenance Supervisor acknowledged the stairwell door is not rated for at least one hour fire resistance.  3.1-19(b)		mid 1980's. The facility immediately ordered a door wone hour fire rating to be inst as soon as it is delivered to the facility. All residents/visitors have potential to be affected. Nother vertical enclosed struct exit in the facility. A door with rating of 3 hours was installed 6/25/12. The Maintenance stainstalled the door on 6/25/12. The Maintenance staff is responsible for the proper for operation of the door. Maintenance will immediately notify Administrator of any problems with the operation of door.	vith a alled ne ave lo ures a fire d on ff

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	A. BUILDING 01		COMPLETED	
		15E594				06/13/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MCCIVAL	EY HEALTH CARE	CENTED			136TH ST		
MCGIVIN	ET HEALTH CARE	CENTER		CARIVIE	EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144 SS=F	NFPA 101 LIFE SAFETY Concentrators are in exercised under month in accordance 3.4.4.1.  1. Based on reconstruction for the facility failed written record of the starting batter generator was made weeks. Chapter is required storage in connection with a systems shall be not more than 7 concentration maintained in full manufacturer's specific batteries shall be immediately upon Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a writter performance, exercipairs for the generator and a having jurisdiction practice could affand visitors.  Findings include	ODE STANDARD Inspected weekly and load for 30 minutes per ance with NFPA 99.  Indicate the entergency and interview, and interview and interview, are so of the emergency and interview and intervals of the emergency and intervals of NFPA 99 to the essential electrical inspected at intervals of days and shall be all compliance with pecifications. Defective repaired or replaced in discovery of defects.  PA 110, 6-3.6 requires to batteries, including and intervals of not more apter 3-5.4.2 of NFPA 99 in record of inspection, ercising period, and enerator to be regularly to an interval in the authority on. This deficient fect all residents, staff	K01	44	DisclaimerPreparation, submission and implementation of this Plan of Correction does constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contite survey findings through informal dispute resolution, for appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raisful possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers responses, credible allegations compliance and plan of correct as part of its ongoing efforts to provide quality care to residen McGivney Health Care reserves the right to modify policies and procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility. The generator was the result of a generous grant as the facility is not required to have a generator. The facility complet weekly rounds with corporate maintenance staff, the facility failed to document them. The	not  th test mal  its s of tion ts. es l/or	07/13/2012
	Based on review	of "Generator Log"			facility immediately documente	ed	

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	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	NSTRUCTION  01	COMPLI	ETED
AND PLAN	PROVIDER OR SUPPLIER  SUMMARY S'  (EACH DEFICIEN  REGULATORY OR  documentation w  and Maintenance record review fro  a.m. on 03/28/12 generator starting records for twent one week period 06/12/12 was no Instead of weekly starting batteries once per month i	CENTER  FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  With the Administrator Supervisor during om 9:15 a.m. to 11:10  , weekly emergency g battery inspection by five weeks of the thirty of 11/15/11 through a available for review.  y inspections of the the facility conducted		LDING G STREET A 2907 E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  their weekly inspections which includes battery testing for the emergency generator. The facility completed monthly inspections of the generator be failed to document the monthly load test which was schedule every Saturday at 2 a.m for the minutes. The facility immediate included the monthly load test their documentation and condition that it is the facility put a sign which identification.	ut y d hirrty telly in ucts	ETED
	Log for the period June 2012. The document the darwas conducted. Power Systems, for Generac Powdocumentation dinitial startup dat diesel fired emer transfer switch owas 11/15/11. Butime of record restated this emergacility was oper 11/15/11 and ackemergency generinspection record of the thirty one	d of January through Generator Log does not the the monthly inspection A review of Generac Inc. "Startup-Inspection er Systems Generator" ated 11/15/11 states the the for the 80 kilowatt gency generator and peration for the facility ased on interview at the view, the Administrator gency generator for the facility at the stational on or after throwledged weekly factor starting battery as for twenty five weeks week period of 11/15/11 as was not available for			the manual stop over a manual stop. All residents/visitors have the potential to be affected. The facility developed a MHCC Weekly Generator Inspection form. Reviewed and revised to MHCC Monthly Generator form The facility put a sign which identifies a manual stop over a manual stop. The Maintenance Supervisor is responsible to completed and document weekly generator inspections, monthly generator inspections and to ensure the sign remains under the manual stop. The HFA is responsible to monitor and ensure compliance of generator inspections both weekly and monthly on the for which will be ongoing.	he m.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 01	COMPL		
ANDILAN	OI CORRECTION	15E594		LDING	01	06/13/	
		10000	B. WIN		DDDDGG GWY GW W	00/13/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2 D 1						
		ord review and interview,					
	1	to ensure a monthly load					
		ergency generators was					
		of 7 months using one of					
		ng methods: under					
		ature conditions, at not					
		the Emergency Power					
		meplate rating, or loading					
		e minimum exhaust gas					
	-	recommended by the					
		hapter 3-4.4.1.1 of NFPA					
	_	hly testing of generators					
		gency electrical system to					
		with NFPA 110.					
	Chapter 6-4.2 of	NFPA 110 requires					
	generator sets in	Level 1 and Level 2					
	service to be exe	rcised at least once					
	monthly, for a m	inimum of 30 minutes,					
	using one of the	following methods:					
	a. Under operatir	ng temperature conditions					
	or at not less that	n 30 percent of the EPS					
	nameplate rating						
	b. Loading that n	naintains the minimum					
	exhaust gas temp	peratures as					
	recommended by	the manufacturer.					
	The date and tim	e of day for required					
	testing shall be d	ecided by the owner,					
	_	operations. NFPA 99,					
	_ ·	a written record of					
	_	rmance, exercising					
		s shall be regularly					
		vailable for inspection					
		having jurisdiction. This					
	<u> </u>						

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	OF GODDECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		15E594	B. WIN	G		06/13/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					136TH ST		
MCGIVN	EY HEALTH CARE	CENTER		CARME	L, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	deficient practice						
	residents, staff ar	nd visitors.					
	Findings include	:					
	S						
	Based on review	of "Generator Log"					
		vith the Administrator					
	and Maintenance	Supervisor during					
		om 9:15 a.m. to 11:10					
	a.m. on 03/28/12	, monthly load test					
		vas not available for					
	review for the pe	eriod of November 2011					
	_	12. A review of Generac					
	" "	Inc. "Startup-Inspection					
		er Systems Generator"					
		ated 11/15/11 states the					
		e for the 80 kilowatt					
	_	gency generator and					
		peration for the facility					
		ased on interview at the					
		view, the Administrator					
		gency generator for the					
		ational on or after					
		nowledged monthly					
		entation was not available					
		e period of November					
	2011 through Ma	•					
		· <i>y</i> <del></del> -					
	3.1-19(b)						
	3. Based on obse	ervation and interview,					
		to ensure the remote					
	manual stop for						
		dentified as the manual					
	"" " " " " " " " " " " " " " " " " "						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				onstruction 01	(X3) DATE COMPL		
1111212111	or conditions	15E594		LDING	<del></del>	06/13/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	1			136TH ST		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI TELLACT)		DATE
		Health Care Facilities,					
	_	s generator sets installed					
	_	er sources shall meet the NFPA 110, Standard for					
	_	dby Power Systems.					
		5.6 requires Level II					
	· ·	l have a remote manual					
		type similar to a break					
	-	ated outside of the room					
	~	mover is located.					
	_	planatory Material at					
		the manual shutdown					
		oriately identified. This					
	deficient practice	•					
	•						
	residents, staff an	ild visitors.					
	Findings include	:					
	Based on observa	ation with the					
	Administrator an	nd the Maintenance					
	Supervisor durin	g a tour of the facility					
	from 11:10 a.m.	-					
		note manual stop for the					
		rator is located at the					
		the Maintenance Office					
	and is identified	as "Bypass Delay."					
		was transferred to the					
		rator with manual startup					
	at 12:37 p.m. on	06/13/12 and when the					
	•	switch was activated at					
		5/13/12, the emergency					
	_	ff within ten seconds.					
	Based on intervie						
		Maintenance Director					
	<u> </u>						

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	OF OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:  15E594	A. BUILDING B. WING	01		LETED B/2012
MCGIVN	PROVIDER OR SUPPLIE	CENTER	STREET A 2907 E CARME	ADDRESS, CITY, STATE, ZIP 136TH ST EL, IN 46033	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG	acknowledged th	he remote emergency shut gency generator is not	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE

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